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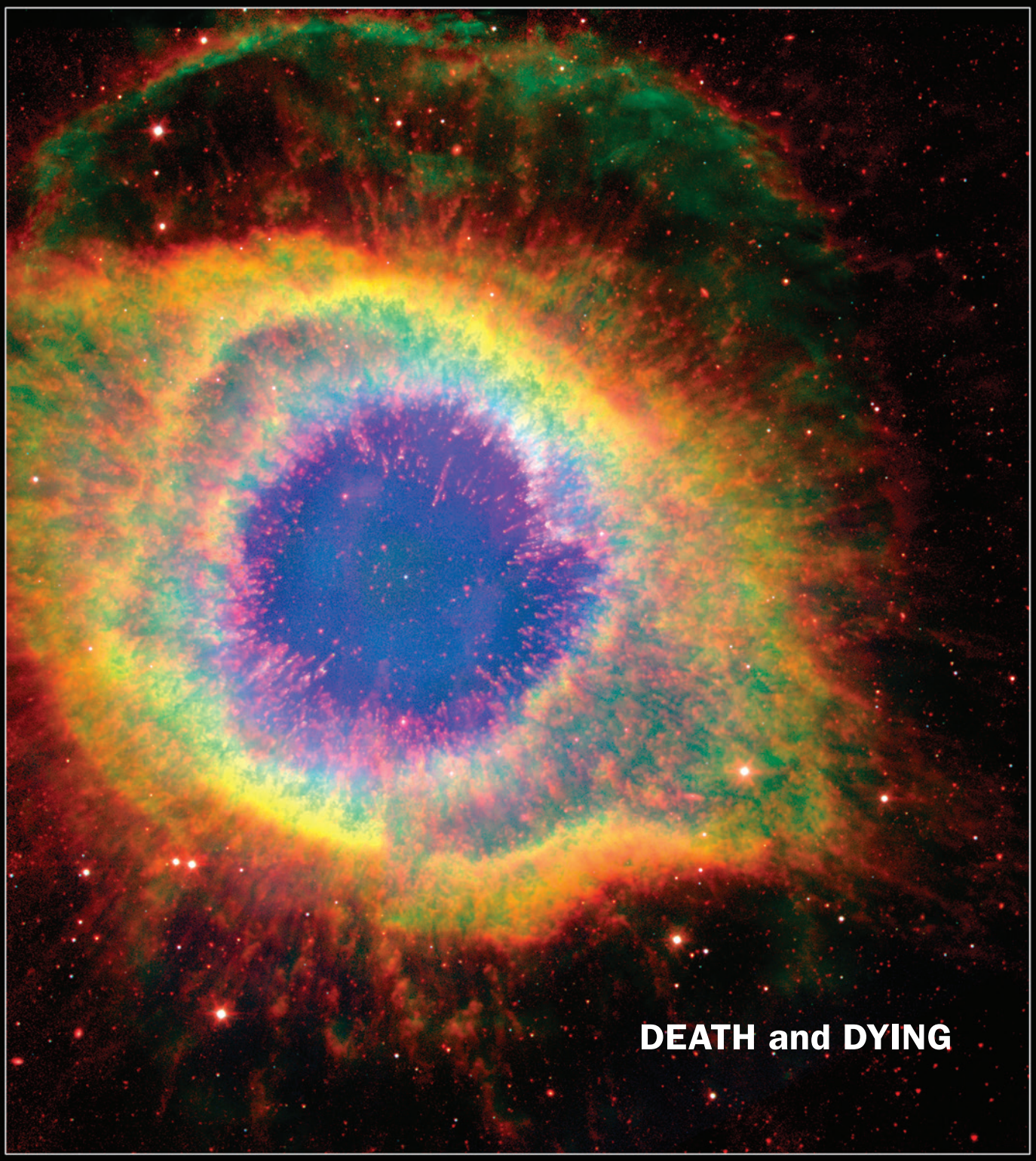

DEATH and DYING

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Volume 66, Number 4 Fall 2015

Sonoma Medicine

The magazine of the Sonoma County Medical Association

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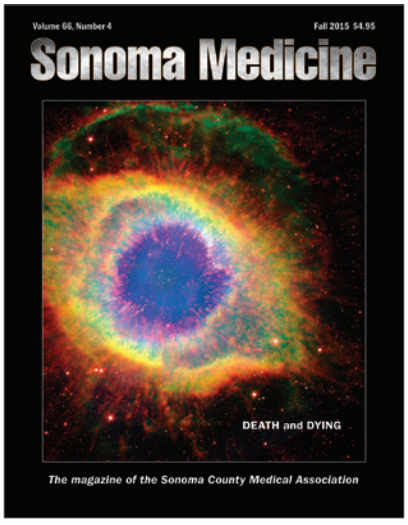

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Death and Dying

James DeVore, MD

This issue of *Sonoma Medicine* focuses on death and dying. But I'd like to think it's also about life and living. Death is a topic of universal concern. Let's face it: we all need to deal with our own mortality. We will all die. Every single one of us has limited time left; it's only a matter of when. But before we get too morose about our ultimate demise, maybe there's another angle here. Can we take this emotionally charged examination of dying and gain insights about what we are all doing right now: living? Consider these observations about death and dying and see if they also apply to life and living:

Everyone is touched by death (life). We all know of someone who has been consumed by the dying (living) process but who carries on in the time left on this planet with reckless passion and the joy of being fully and utterly alive. We can't help but admire those who somehow look death (life) square in the eye and cherish every precious moment without fear or regret. These are our role models who teach us how to die (live) with dignity, serenity and faith.

Dr. DeVore, a Santa Rosa family physician, serves on the SCMA Editorial Board.

The very act of dying (living) is an emotional roller-coaster of uncertainly, despair and pain interspersed with times of beauty, love and clarity. We will all die, but we are ultimately united by our experience of being alive.

I am fascinated that we can easily interchange the words *death* for *life* and *dying* for *living* and still hold onto essential truths. What's going on here? How can we characterize the two most opposite parts of the human experience in such similar terms?

Whether we have 60 hours, 60 weeks or 60 years to live, we all face the most basic questions. What is really important? How do we want to live? What kind of relationships do we really value? What conversations do we want with loved ones? What really matters? Obviously those facing a terminal illness have a much sharper focus on these essential questions—they have less time to figure it all out. Perhaps this is why caring for a dying patient can so often bring deeper meaning and purpose to those who will remain behind.

Consider the article by Dr. Steve Hadland about patients' right to die. Shouldn't the fundamental human value of making personal choices extend to everyone regardless of whether they are dying or living? In his article, we are confronted with another fundamental concept that applies directly to everyone living or dying: how do we balance the desire for comfort with our quest to remain aware and mindful of our surroundings? Dr. Scott Eberle's article on hospice care goes straight to the intersection between life and death and speaks to our values and culture around how we deal with the terminally ill. Dr. Gary Johanson's article on advance care planning asks even the most vigorous of the living to contemplate death and choices we might want to make as we face our mortality.

This edition is really for everyone: the living, the dying and those of us who will die someday. To me, almost all deep philosophical thought about death eventually leads to "carpe diem." We better seize the moment since, as we learn from those who are facing imminent death, we might have less time than we think. To that point, I once started creating a "bucket list" but gradually realized the complete lack of satisfaction I felt when I clicked items off. Is how long we live and how many things we accomplish and all of our achievements and adventures and experiences really what it's all about? Or is there something else that really gives true meaning and purpose in our lives? Perhaps it's really more about the journey—maybe how we go about the process of living is what matters the most. Maybe this edition's examination of death (life) and dying (living) will help us find our way. ◇

Email: james.devore@stjoe.org

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Hospice Alternatives to Physician-Assisted Suicide

Steve Hadland, MD

On Sept. 11, the California Legislature passed right-to-die legislation and forwarded it to Gov. Jerry Brown. As of press time, Brown had not indicated whether he will sign or veto the bill, but the outcome seems inevitable. Even if Brown vetoes the bill, physician-assisted suicide (PAS) is coming to California, if not this year then sometime soon.

The Field Poll has found widespread public support for PAS since as far back as 1979, with 60–70% in agreement over three decades and only 20–27% opposed. Five other states have established the legality of PAS either by legislation or court decisions.

Once PAS arrives, California physicians will no longer be passive observers of scenes playing out in other states and nations. An entirely new set of options and responsibilities will appear, regardless of where we currently stand on the issues. We will not have the force of law and social agreement supporting us, and we will no longer be able to avoid engaging with viewpoints that we may strongly disagree with.

Many physicians remain opposed to a PAS law; and if such a law is passed, they will not participate in what the law allows. These doctors will be in a minority, perhaps not within the profession, but certainly within the electorate. Thus it behooves us to carefully consider the arguments on both sides of this issue, and also to probe our hearts, our guts and our personal experience for answers before this wave breaks.

Dr. Hadland is a hospice physician at Hospice of Petaluma.

End-of-Life Options

Hospice and palliative care physicians have been providing high quality care for dying patients and their families since the first modern hospice program was established in England a half-century ago. In a position paper for the American College of Physicians—American Society of Internal Medicine, Drs. Timothy Quill and Ira Byock thoroughly discuss the use of current hospice practices to manage suffering at the end of life.[1] As stated in their introduction:

> When provided by a skilled, multidisciplinary team, palliative care is highly effective at addressing the physical, psychological, and spiritual needs of dying patients and their families. However, some patients who have witnessed harsh death want reassurance that they can escape if their suffering becomes intolerable. In addition, a small percentage of terminally ill patients request that death be hastened. This paper presents terminal sedation and voluntary refusal of hydration and nutrition as potential last resorts that can be used to address the needs of such patients. These two practices allow clinicians to address a much wider range of intractable end-of-life suffering than physician-assisted suicide (even if it were legal) and can also provide alternatives for patients, families and clinicians who are morally opposed to physician-assisted suicide.

As defined by Quill and Byock, palliative sedation "is the use of high doses of sedatives to relieve extremes of physical distress. . . . The purpose of the medications is to render the patient unconscious to relieve suffering, not to intentionally end his or her life."

Our experience at Hospice of Petaluma, with an average daily census of 70 patients, is that palliative sedation is invoked less than once a year, and then only when all other means of controlling pain and suffering have been ineffective. Before palliative sedation is instituted, the case is thoroughly evaluated by the hospice physician, including making in-home visits and obtaining detailed informed consent. The patient is also screened for depression. The hospice physician consults with the primary physician or another qualified physician in his or her absence. The intervention itself

is usually accomplished with carefully titrated doses of subcutaneous midazolam via a CADD pump.

The practice of palliative sedation has been in place for 15–20 years and has been reviewed by many ethics committees and thoroughly discussed in the literature. There is widespread acceptance of the legality and ethics of this procedure, though not complete consensus. Some see little difference between palliative sedation and PAS or even euthanasia, since death is the expected outcome. However, when used as a last-resort intervention with someone who has only hours to days to live, palliative sedation does not hasten death appreciably. Instead, it provides great comfort to the family and, as far as we can tell, to the dying patient. Courts have ruled that the intention to fully manage symptoms with palliative sedation is what matters, and that death is expected in all these patients—but it is not the intended outcome.

Quill and Byock also discuss the conscious choice to cease eating and drinking in order to hasten one's death. They present data indicating that stopping eating and drinking is far less symptomatic than most of us believe. It does take a strong will and great sense of purpose to put such a plan in place and follow it to the end, but it is not a painful way to die. Here, too, there need to be safeguards to ensure that there is in fact an incurable illness with current or anticipated suffering, that there is adequate consultation, and that clinical depression is not a factor.

Patients nearing the end of the dying process (or even much sooner) commonly lose their appetite. Families often encourage their loved one to keep trying to eat, thinking that "food is life." The hospice team, however, generally discourages this type of eating because it often results in nausea, vomiting and increased pain. Observational studies have consistently shown that patients who undergo terminal dehydration do not report high levels of discomfort and that symptoms that do occur are consistently relieved by oral care or ingestion of small amounts of food or fluid.[2]

Taking a Stand

The Quill and Byock position paper outlines how effectively even the most extreme symptoms encountered during the end-of-life process can be managed. This finding is aligned with my own experience as a hospice physician, and it provides a convincing argument that legalizing PAS may be unnecessary. I realize, however, that many people outside the medical profession and some within it may not be reassured by the option of hospice care.

So, why is society choosing physician-assisted suicide? Perhaps it's because the PAS option allays the fears of patients and their families facing terminal illness, especially the fear of uncontrollable pain and suffering and the loss of control of physical and mental functions. People dread these outcomes, and many feel that the loss of privacy, autonomy, dignity and control often experienced in the dying process is simply unacceptable. This, along with the desire to freely determine the manner and timing of one's death, are the main motives of advocates for right-to-die legislation.

The principle of the patient's autonomy in medical decision making is a powerful one. In right-to-die scenarios, it stands in opposition to the physician's longstanding proscription against participating in the hastening of death. A law legalizing PAS would put doctors in a serious bind between loyalty to tradition vs. loyalty to the autonomy principle.

When PAS arrives, we physicians will no longer be able to stand on the formerly solid ground of legal, moral and religious imperatives that have been in place for millennia. Each of us will have to carve out a position based on personal belief and life experience, and not rely on passed-down authority nor a previous social consensus. This process of self-searching is not just philosophical. Many of us will be asked to advise others facing these questions and offer our considered views on the subject. We will be asked where we stand in this controversy.

I've done a lot of reading and even more thinking about how I will deal with the issue of physician-assisted suicide if and when it becomes legal. As it stands now, I do not oppose the PAS legislation. I trust the guidelines will be followed and that significant abuses will not occur. People who emphasize maintaining autonomy and control over their dying process will be gratified by the availability of medically provided means to choose the time of their dying. Most will not use these means but will find their presence a comfort. I do not and will not judge those who use medications prescribed under the law to take their own lives. I believe that is within their rights under the principle of autonomy.

I will not, however, give PAS my enthusiastic backing. I know this sounds contradictory, but there it is. Instead, I will continue to campaign for the expanded provision of hospice and palliative services. Good information on hospice care is not as available to doctors and patients as it should be, and much more work needs to be done. Society should strive to provide high quality, affordable hospice services to all who can benefit from them.

I believe there is a value to enduring the mystery, tragedy and majesty of the dying process. I have seen profound transformations occur in this setting for patients and their loved ones, as well as in my colleagues and myself. The hospice movement has helped pull death from the shadows of denial and repression, and it has given comfort and guidance to many. My continuing commitment to providing high quality end-of-life care on the hospice model—a strong alternative to physician-assisted suicide—will stand as my response to this debate. ◇

Email: hadland@svn.net

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2. McCann RM, et al, "Comfort care for terminally ill patients: the appropriate use of nutrition and hydration," *JAMA,* 272:1263-66 (1994).

Getting Advance Care Planning Right

Gary Johanson, MD

Advance care planning that is delayed until near the end of life is more aptly termed Last Minute Care Planning—and it happens all too often. Instead of waiting until the last minute, good advance care planning (ACP) is essential well upstream: anytime a person reaches age 60 or is facing a serious chronic illness. In fact, ACP is wise for all adults, even those in good health. Doing ACP well improves the downstream outcomes.

ACP is emerging as an integral part of health care reform. It is a process, not an event. In the initial phase, it involves thought, conversation, sharing and documentation. Then it requires periodic review as patients age and as their health and priorities change.

My Care My Plan: Speak Up Sonoma County is a local initiative designed to address ACP earnestly and systematically. The project was launched by the Committee for Health Care Improvement as part of Sonoma County Health Action, a broad effort aimed at making Sonoma the healthiest county in California by 2020.

My Care My Plan encompasses a broad upstream approach to improving care for people with life-limiting illnesses by addressing ACP and increasing awareness about end-of-life issues. The initiative is intended for all adults in Sonoma County in all health conditions, at all ages, and in all socioeconomic groups, with a particular focus on older adults facing their final stages of life. Goals of My Care My Plan include:

- Raising public and medical community awareness of ACP, particularly in end-of-life scenarios and in cases of advanced age and/or illness.
- Normalizing the conduct of conversations between patients, families and medical providers about priorities and wishes.
- Motivating local residents to complete Advance Healthcare Directives.
- Partnering with local health systems to provide high quality care aligned with patients' wishes and their personal and cultural values.

My Care My Plan has already reached more than 500 people through educational presentations on ACP and workshops on completing advance healthcare directives. The project is ongoing and will soon reach wider audiences through a series of KRCB television spots on the importance of ACP. (For more information on My Care My Plan, visit www.mycaremyplan-sonoma.org.)

Dr. Johanson, a palliative medicine specialist, is medical director of Memorial Hospice and of palliative care services for Santa Rosa Memorial Hospital.

Rationale

The Institute for Healthcare Improvement is a prominent, nationally recognized program focused on identifying and implementing best practices for improving health. Their president and CEO, Don Berwick, famously observed that "Improving the U.S. health care system requires simultaneous pursuit of three aims (the Triple Aim): improving the patient experience of care, improving the health of populations, and reducing per capita costs of health care."[1]

The Gundersen Health System in Wisconsin is one of many health systems that has produced impressive results by implementing the Triple Aim. Among health systems nationwide, Gundersen ranks in the top fifth percentile for health outcomes and customer satisfaction—and they achieve these results at a lower cost than other systems.[2] Concomitant with these results is a 97% participation rate in ACP among Gundersen's adult population.

According to the Institute for Healthcare Improvement, high quality ACP involves a continuous cycle of information sharing, education, shared decision making, goal setting and care planning. The goal of these activities is to reduce unwanted and wasteful treatments and make smoother transitions between care settings.

High-level support for the importance of ACP comes from The Berkeley Forum, a consortium of CEOs from California health systems, health insurers and physician organizations, along with state regulators and policymakers. The consortium recently made detailed recommendations for improving the affordability and quality of health care for all Californians.[3] Their extensively researched report outlines the literature-supported value of vastly extending access to palliative care services and ACP.

The public feels that making their wishes known is important, but they are not sure how to do that, much less do it well. One study found that 83% of the public felt documentation of wishes in writing was somewhat to very important, but only 36% had documented their wishes.[4] In the My

Care My Plan workshops carried out to date, a repeated theme from the public is concern about whether physicians and the medical community will listen to them, work with them and honor their wishes effectively.

Facilitating ACP

We physicians need to provide better information about ACP to our patients, and we need more and better information about our patients' wishes through specific inquiry. Armed with this shared information, we can help our patients make choices for care.

Consider the following analogy. When dining at a fine restaurant, we might ask the waitperson or sommelier for recommendations. Do we like to hear responses such as, "I don't know, you decide" or "It's all good"? Or do we prefer assistance? Do we prefer an attempt to align with us, accompanied by inquiries as to what styles of food or wine we like or would like to avoid and a detailed description of items on the menu? Based on those considerations, do we want to get advice on which choices we might prefer and why?

Why shouldn't physicians similarly be advisors to our patients on the much more important topic of ACP?

Prognostic information is of crucial importance for patients and their families. More and more literature is documenting how patients adjust their preferences based on prognostic information and express a more positive experience through having this information. One study showed how patients changed their code status preferences once they were aware of the chances for a good vs. bad outcome.[5] Another

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Essential Elements of ACP

- Physician, patient or family initiate ACP discussions.
- Patient receives full access to relevant information.
- Conclusions are drawn after careful thought over a period of time and a series of conversations.
- ACP documents are completed accurately and in good faith. They include:

  Advance Directive/Living Will/ POLST. Standardized documents that give broad insights as to wishes for care.

  Durable Power of Attorney for Healthcare. Names surrogate for health care decisions.

  Preferences and Goals of Care. Non-standardized worksheets describing values and preferences.

  Willed Body program/donor wishes. Provision of remains for scientific uses or transplant.
- ACP documents are accessible at the bedside.
- Preferences are converted into medical orders.
- Plans are transferred with patient to all sites of care.
- Good ACP is a dynamic process, is periodically reviewed and is hard-wired into the workflow of a health care system.

showed how a disease-specific planning intervention greatly influenced surrogate understanding of patient goals for future medical treatment.[6] A randomized controlled trial showed how video illustrations enhanced end-of-life discussions for patients with cancer.[7] There are many more examples of how ACP enhances outcomes.

An Improved Model of ACP

One of the main criticisms of ACP is the difficulty of projecting how a patient might feel in advance of an event and of knowing what treatments the patient would or would not want in an unpredictable scenario. While the task is difficult, reacting to such a challenge by doing no planning at all is a bad solution.

To make ACP more practical and useful to implement, researchers have proposed an improved model that prepares patients and their surrogates to participate with clinicians in making the best possible in-the-moment decisions.[8] The improved model provides practical steps on how to help a patient by exploring their personal situation; by educating, motivating and preparing; and by assisting in the choice of an appropriate surrogate. Physicians can also help patients by asking specific questions, such as:

- What do you know about your prognosis?
- What matters to you most, especially if time is short?
- What worries you most about what might come, and what outcomes would be unacceptable?
- If you were severely ill, are there specific treatments you feel might be too much under any circumstances?
- What do you want your friends/family/doctor to really understand about your wishes if time were to be very limited?
- What trade-offs are you willing to make to have a chance of some recovery? What suffering is acceptable for the sake of the possibility of added time?
- Which potential surrogate will be willing and able to represent your wishes best?

Most important, the improved model offers a framework for assisting patients and their surrogates by establishing "leeway in decision making." Such leeway balances the wishes your patient may have expressed in the past with what doctors are saying about his or her current condition and what they are able to do. Leeway also gives guidance to surrogates on how to proceed when doctors are recommending something different from what the patient was expecting or for which he/she was hoping. Moreover, it gives patients' loved ones permission to work with doctors to make the best decision they can for the patient in the moment. Finally, leeway in decision-making helps to define a treatment pathway that best balances the benefits and burdens of treatment.

Recommendations

All adults, even young and healthy, can potentially benefit from ACP, as unforeseen trauma or sudden medical

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illnesses can and do occur. In these cases, previous values discussions and surrogate designation can be useful, even though initial treatment is likely to be full-court press. More important, though, is to focus on patients most vulnerable to change in condition, as shown in the table below.

Have "the conversation" with your patients when they are feeling well and are able to speak for themselves—before an acute exacerbation of chronic illness or a critical illness strikes. When illness is very advanced at or near end stage, it is important for physicians to remember that end-of-life is not just a medical experience, it is also an emotional and human experience.

Become better informed, if necessary, with techniques on how to conduct difficult conversations. Refer to a palliative care specialist if needed. Conversations should become a routine part of patient assessments and updated as a patient's condition and life status changes. Such conversations will be encouraged by a specific CPT code next year, but for now, by using the >50% counseling convention we already have at our disposal, we can bill a higher level of care on any given visit attached to another primary diagnosis such as Stage IV Cancer, COPD or CHF.

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Physicians with ACP expertise can join the My Care My Plan speaker's bureau and help provide community presentations. For more information, visit www.mycaremyplansonoma.org.

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A Sufficient Length of Stay

Scott Eberle, MD

In hospice circles, a person who dies within a week of admission is said to have had a "short length of stay," or SLOS. The SLOS is not uncommon, as balancing the promise of life-prolonging therapies and the desire for a quality end of life is often challenging. Nationwide about 35% of all hospice admissions are SLOS.

The following is a true story about the author's aunt, although a few details have been altered to maintain her anonymity.

I'm calling about Aunt Fiona," said my mother, her voice cracking. "She's decided to quit all treatment and leave the hospital. Daniel says she'll be coming home tomorrow, with hospice there to meet her."

"I'm so sorry to hear that, Mom."

"Tell me! I'm having such a hard time believing this. Last time we saw her she was so alive, so vibrant. And that was just four months ago. I don't understand why she would give up like this."

"You're right. Hard to reconcile the bad news with who we saw at the beach house."

I, too, was surprised—not by my aunt's decision to choose hospice, but by how soon she had reached this final stage of life. Intuition (and years of hospice experience) told me that Fiona's "giving up" was likely a wise choice. She was a sharp, no-nonsense, in-control person: the sort who wouldn't hesitate to fight the good fight—*but only for as long as it made sense.* She would not be the person still reaching for the brass ring of a miracle cure, as the medical merry-go-round spins out of control and then tosses her off. She would not be a person sent home to die a day or two before the end—barely conscious, barely able to communicate. She needed her last days to be in her own home and with her own family.

Dr. Eberle, a family physician, is medical director of Hospice of Petaluma.

Fiona was determined that her version of SLOS would be a *sufficient* length of stay, not a short one.

I began drawing out my mother, to have the two of us trace out Fiona's storyline: from beach-house vacation, to the first news of her ovarian cancer, through chemotherapy, onto surgery, and now receiving hospice care. I wanted to give her (and me) a chance to let the latest news sink in.

In the fall we received initial word about Fiona's diagnosis of ovarian cancer, and we were all stunned. Two months earlier she and Uncle Daniel had flown out from Montreal to join my family for a week's holiday at Stinson Beach. She had seemed fine: looking younger than her 65 years, and as feisty and engaging as ever. She either had been unaware of a health problem, or she had been hiding behind a stoicism learned during her post-World War II youth in Northern England. But ovarian cancer is often referred to as "the silent killer"—some women have so few symptoms—and so I assumed that even she hadn't known at the time.

Soon after the diagnosis Fiona started sending out long engaging email rambles with titles like "On being a cancer patient" and "Living (or dying?) with cancer." She told us how she had loosened her tight budget on red wine, now allowing herself to splurge at $12 per bottle instead of buying cheaper wine by the case. You could see her wry smile as she then added: "But let me tell you, if the prognosis worsens, I'm going up to $25 a bottle." The guilt-free pleasures didn't stop there. More walks with her cocker spaniel on her good days. The return of an old addiction to clotted cream. Luxuriating in bubble baths instead of taking short Spartan showers. In short, she was enjoying life.

In early December, the entertaining missives stopped, replaced by foreboding updates from Daniel. *Off to the hospital for surgery. Unable to move her bowels, and so unable to go home. Refusing all phone calls, even from her children.*

"I hate to say it, Mom, but replaying the whole story, this latest news is not really a surprise. My guess is she's got only weeks left, not months. When time is that short, new priorities come into view."

I paused for a while to let that land, and then added: "And I don't mean buying expensive bottles of red wine."

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We allowed ourselves a short laugh, enough to lighten the moment.

"You're right," she conceded. The truth of the situation had finally sunk in. "Of course you're right. I'm just so sorry to be losing her."

And lose her we did—three weeks later, just after the start of the New Year.

But not until Fiona had had the time she needed at home. Time to meet the hospice nurse, soon to be a trusted ally, who greeted her arrival home with a hospital bed and a gentle touch. Time to get comfortable, deeply comfortable: in her own house, in her own bedroom, in her own body. Time to surrender to the precious moments that still were hers to enjoy, including the occasional sip of an expensive Merlot. Time to say a full and tender goodbye to those she most loved: Daniel, her two children Ruth and Richard, and her dog, Heather.

Not enough time, to be sure. Not nearly enough time. But a "sufficient length of stay" nonetheless. ◇

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Certification of Death: Whose Responsibility?

A. Jay Chapman, MD

Many patients with fatal disease follow a predictable course through their illness that ultimately results in their death. Having one's patient die is always discomforting, but in most of these instances, the physician is prepared for the event. For these cases, there is almost never a question that the patient's physician is responsible for the certification of death and completing the death certificate (DC).

In addition to providing data for leading causes of death and other public health statistics, DCs most immediately allow arrangements for the disposal of the body. Thus, if the family cannot promptly obtain a valid DC, they will at a minimum be terribly inconvenienced. At the other extreme, families can even be shoved into financial ruin if the DC is delayed for a prolonged period since they are necessary for life insurance claims, pension benefits, settling of estates (wills, trusts, accessing bank accounts, real estate holdings), Medicaid benefits, and even future marriages where proving the death of a previous spouse may be necessary.

Some patients have risk factors for sudden demise, and their death is quite often unexpected to the patient's family, friends and physicians. The most common and obvious risk factors are hypertension, obesity, diabetes mellitus, hyperlipidemia and seizure disorders. Despite the unexpected nature of these natural deaths, nearly all are under the purview of the attending physician—not the coroner—if there are no suspicious circumstances. By statute, the attending physician must complete the DC. Physicians may not avoid this responsibility by making a "policy" that is contrary to state law.

One common misconception is that the physician must be in physical attendance at the time of death. A physician is considered to be the attending physician if the patient was being seen by that physician or designee in the physician's office or the patient's home, or if the patient was using or refilling prescriptions written by the physician. There are no specified limits as to the time when the patient was last physically seen by the physician.

Patients seen in the emergency room are a different matter. If the emergency physician only performs resuscitative measures and pronounces the patient dead—and the emergency physician was not otherwise seeing the individual as a patient—he or she is only the "pronouncing" physician and is not responsible for completing the DC. The responsibility for death certification still falls to the physician who has been treating or "attending" the patient, provided the death is due to natural means and didn't occur under valid suspicious circumstances.

In some cases, the emergency physician diagnoses and treats a natural illness unrelated to trauma or suspicious means. If the patient succumbs to that illness, the emergency physician is responsible for signing the DC, regardless of any "policy" established by the hospital or other entity. In these cases, the emergency physician is considered to be the attending physician, no matter how long he or she has been treating the patient.

The Coroner's Role

California law specifically provides that the coroner has the discretion to determine the extent of inquiry to be made in any given case. The law further provides that if the inquiry determines that the "physician of record" has sufficient knowledge to reasonably state the cause of death, the coroner may require that physician to sign the DC.

The coroner is notified in most cases of sudden and unexpected death. The case is then investigated to the extent that the coroner deems necessary. The attending physician is responsible for completing the DC when the coroner determines that the death was due to natural causes, that there are no suspicious circumstances, that there is a physician of record, and that the death was reasonably due to a condition or conditions for which the deceased had been seen by that physician. The identity of the physician of record is determined most often via history given by family or friends or through medical

Dr. Chapman is a forensic pathologist at the Sonoma County Coroner Unit.

records or prescriptions possessed by the deceased.

Physicians notified by the coroner's office of their responsibility to sign the DC sometimes object because they were not present when the patient died. This misconception has been discussed above and is not a valid reason for refusing to sign the DC. The only valid reason for not completing the certificate is that trauma or overdose initiated the process that led to the patient's demise, or that the attending physician is also deceased.

Some physicians believe that their simple refusal to sign the DC obligates the coroner to assume jurisdiction. In fact, the coroner is under no such obligation. The practical effect of such refusal in many instances is to create a great inconvenience for the patient's family.

Another reason given for not wanting to complete the DC is that the physician cannot state the exact cause of death. An exact cause of death is not required on the DC. The DC only requires that the cause of death be based upon reasonable medical probability. If the physician feels more comfortable doing so, he or she can qualify the cause of death with a modifier such as "probable."

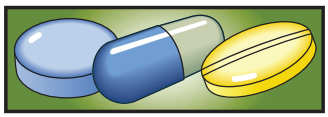
Autopsies

Some physicians may believe that their absolute or adamant refusal to sign the DC will result in an autopsy; but that is highly improbable. What is much more likely to happen is the following:

- Sonoma County taxpayers will incur considerable expense for bringing the body to the morgue, where an autopsy is unlikely to be performed. Instead, the pathologist will only undertake an external examination of the body.
- The family of the deceased will be inconvenienced and may have to pay an increased fee for the funeral home to retrieve the body from the morgue.
- The cause of death will be determined by the pathologist who examines the body.
- The pathologist will determine the most probable cause of death by investigating the circumstances of death and the medical records. These records will be subpoenaed by the coroner and must be provided from the physician's office or other treatment facility—another inconvenience and expense for the physician or facility.

In these cases, the attending physician is in a much better position to provide the medically probable cause of death, thereby eliminating the inconveniences and expenses that are otherwise involved. The coroner's office does not exist to provide autopsies that should properly be done by hospital or private pathologists.

If the coroner notifies you, as the attending physician, that your patient has died, that the death has been investigated, and that the death is due to natural means, you should have no hesitancy in completing the DC—unless you know of some valid circumstance that the coroner did not investigate. I don't know of any case in which a physician has been sued for a cause of death stated on the DC.



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* http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm

Another misconception regarding the DC is that it may be signed at your leisure. California law provides that the DC must be signed and made available to the funeral director no later than 15 hours after the time of death.

Bear in mind that if you have been treating a patient for a potentially fatal condition, you have obviously been billing with a code for that condition. It goes without saying that if you are capable of billing for the patient's condition, you are quite capable of placing that condition on the DC!

Completing the DC

The **cause of death** is the disease, injury or abnormality that, either alone or in combination, caused the sequence of events that ultimately led to death. The terms *initiating, proximate* or *underlying cause of death* may also be used—all with the same meaning. In assigning a cause of death, you should use a simple statement of the underlying cause: the event without which the chain of events leading to death would not have occurred.

The **mechanism of death** is the process by which an organ or organ system fails when there is fatal disease, injury, abnormality or chemical insult: the pathophysiologic change(s) set in motion by the cause of death. The mechanism of death represents the physiologic or anatomic change that is incompatible with life after the body sustains a lethal event. For instance, a dissecting aneurysm of the aorta may cause a laceration of the aortic wall and produce massive hemopericardium with cardiac tamponade, followed by brain death due to anoxia. Death in this case was *due to* 1) hypoxic/anoxic encephalopathy *due to* 2) circulatory failure *due to* 3) cardiac tamponade *due to* 4) massive hemopericardium *due to* 5) aortic wall perforation *due to* 6) dissecting aneurysm of the aorta. All of the "due tos" except the sixth are mechanisms of death. The sixth and final *due to* is the cause of death.

Manner of death must be distinguished from cause of death. The manner of death designations specify how the cause of death came about. The designation can refer to social relationships and personal causation. The customary designations are *natural, suicide, accident, homicide, undetermined* and *pending*. A special designation for people dying from military actions is *operations of war*—with the exception of situations arising in military actions that constitute homicide.

In California only the coroner or medical examiner can certify deaths in which the manner of death is other than natural. Any physician who treats a victim of gunfire, blunt force trauma, poisoning, sharp force injury, or any other kind of violence—or whose death occurred under suspicious circumstances—cannot certify the death and is required to notify the coroner.

Sometimes the underlying cause of death may be overlooked but should properly require that the coroner be notified. A few examples are 1) sepsis due to decubitus ulcers due to paraplegia due to remote gunshot wound to spine; 2) pneumonia complicating acute ethanol or drug toxicity; 3) seizure

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disorder due to closed head injuries due to remote motor vehicle accident, blow to the head or a fall; 4) anaphylaxis due to bee sting; 5) pulmonary thromboembolism due to deep vein thrombosis due to hip fracture due to unwitnessed fall; 6) pneumonia complicating subdural hematoma due to trauma.

Helpful Hints

When completing death certificates, the most important thing to remember is that the statement of the cause of death most often should not include the mechanism of death, although it is sometimes employed for clarity in a particular situation. When the cause of death is stated, it should be the underlying cause—the culprit that initiated the entire series of events leading to death. Terms such as *cardiac arrest, asystole, cardiopulmonary arrest, respiratory arrest, electromechanical dissociation* and *ventricular fibrillation* are all mechanisms of death and cannot be used as the statement of the cause of death.

Simple statements of cause of death include:

- Arteriosclerotic cardiovascular disease
- Hypertensive cardiovascular disease
- Obesity-related heart disease
- Sequelae of diabetes mellitus
- Non-traumatic intracerebral hemorrhage

In summary, death certificates need to be as accurate as possible, and completing the DC should be accomplished with the least expense and inconvenience to taxpayers and the family. The coroner's staff, including the pathologist, are always willing to assist in completing the DC. Physicians can call the office at 707-565-5070 at any time with questions or problems that arise. ◇

For more information on completing death certificates, consult the CDC's Physician's Handbook on Medical Certification of Death *at www.cdc.gov/nchs/data/misc/hb_cod.pdf.*

Treating Atrial Fibrillation, Past and Present

Jaime Molden, MD

Atrial fibrillation (AF) is the most common adult heart rhythm abnormality. When I was a medical resident in the early 2000s, AF was the stepchild of cardiac diagnoses. There was a general feeling, at least in my training, that maintaining sinus rhythm was more trouble than it was worth. A couple of clinical trials published around that time argued that controlling the heart rate and anticoagulating patients with AF yielded better clinical endpoints than trying to maintain patients in sinus rhythm.[1,2]

As I progressed through my training in cardiology and clinical cardiac electrophysiology, I met many patients who suffered the consequences of untreated or undertreated AF. Now, rhythm control of AF is one of the central themes in my medical practice. This article is intended to shine some light on the current state of AF rhythm control, especially as it pertains to the use of common anti-arrhythmic drugs and catheter ablation techniques to maintain sinus rhythm.

Dr. Molden is a Santa Rosa clinical cardiac electrophysiologist.

First, a brief AF primer. Historical data suggest a link between AF and mortality.[3] While not an acutely life-threatening arrhythmia, AF can have catastrophic consequences if under-recognized and undertreated. Research has repeatedly found a strong association between AF and stroke. Generally, the AF population has a five-fold greater risk of stroke during their lifetime than patients without AF.[4] The mechanism of stroke is cardioembolic. Current understanding implicates the left atrial appendage—a small digit-like structure attached to the anterior aspect of the left atrium—as the common site of thrombus formation, although other sites in the left atrium can also harbor a clot.[5]

Cardiomyopathy and heart failure are definite consequences of AF, particularly when the heart rate is allowed to spin rapidly out of control (so-called tachycardia-mediated cardiomyopathy, or tachymyopathy). Patients with other types of heart disease are often particularly susceptible for congestive heart failure symptoms associated with AF, even if the left ventricular systolic function is known to be normal. Other patients may experience life-changing symptoms of fatigue (insidious and often overlooked), palpitations, shortness of breath, decreased exercise tolerance, chest pain, lightheadedness and syncope.

Our current classification of patients with AF suggests a clear understanding, but don't be fooled! In current and past guidelines, physicians are encouraged to classify AF patients as *paroxysmal* or *persistent*. Paroxysmal patients are those with self-terminating episodes lasting less than a week. Persistent patients require an intervention to stop episodes that would otherwise continue for more than week. The term *longstanding persistent AF* is used to describe a patient who has remained in the arrhythmia for more than a year.[6]

To the cardiac electrophysiologist, *paroxysmal* suggests that there is perhaps only an electrical trigger that needs to be addressed. There are paroxysmal patients who have one or more focal atrial tachycardias (arrhythmias arising discretely from a single source area). Treatment of these tachycardias can be curative.[7] In contrast, persistent AF suggests that electrically and/or structurally abnormal tissue is "driving" the arrhythmia indefinitely (a common cause being fibrosis/scar tissue in the atria). Persistent AF also brings up the broader issue of comorbid disease states that may contribute to the

persistence. Despite their differences, there is immense overlap between the paroxysmal and persistent categories. In fact, some patients with persistent AF may revert to a paroxysmal disease state after receiving treatment.

The tools for maintaining sinus rhythm have been the same for many years: 1) direct-current cardioversion to convert patients from AF to sinus rhythm and 2) anti-arrhythmic drugs (AADs) with a lousy risk/benefit ratio to maintain sinus rhythm over time. Studies have found that amiodarone is the most effective drug for maintaining sinus rhythm. The Canadian Trial of Atrial Fibrillation, for example, demonstrated that 65% of paroxysmal patients on amiodarone were arrhythmia-free over 16 months compared to 37% of those taking propafenone or sotalol, commonly used AADs with fewer extra-cardiac side effects.[8]

Despite the low rate of success with AADs, the rate of side effects over time is higher than for other classes of medicine. Approximately 30% of patients in a recent meta-analysis of AAD trials had a significant clinical side effect, and some patient deaths were attributed to AAD use.[9] The efficacy of the newest AAD to come to market (dronedarone) is only comparable to the non-amiodarone medications, and may be worse[10]

Given the problems with AADs, it is easy to understand why non-pharmacologic approaches to AF, such as ablation therapy, have risen to prominence. Support for ablation therapy, which modifies abnormally functioning cardiac tissue, has come from two main sources. The first was the introduction of the Maze surgical procedure in the 1980s. For the "cut-and-sew" Maze, surgeons made a series of cuts into the tissue of both atria and then sewed the cuts back together. The idea was to disrupt abnormal electrical impulses and reentry phenomena in the atria, allowing sinus impulses to funnel down to the atrioventricular node and then to the ventricles. Properly done Maze procedures were shown to have good results.[11] After some cardiologists, newly branded as cardiac electrophysiologists (EPs), began trying various ablation technologies to cure basic arrhythmias like atrial flutter and supraventricular tachycardia, AF became an obsession.

The second milestone in the evolution of AF ablation came in the late 1990s[7] from a group of EPs in France led by Dr. Michel Haissaguerre. His name bears referencing because many of the concepts employed in modern complex arrhythmia ablation have come from his group. In a landmark clinical study by Haissaguerre's group, patients with paroxysmal AF had electrode catheters placed in several locations within the atrial chambers, including the pulmonary veins.[7] The investigators waited for medically facilitated episodes of AF to occur and found that the common sites of origin were within one or more of the pulmonary veins that connect to the left atrium.[7] This finding led to the pulmonary vein isolation (PVI) procedure. In this procedure, surgeons use catheter ablation to create scar tissue around the pulmonary veins. Because scar tissue is not electrically conductive, the idea is that abnormal signals being generated within the veins cannot influence the remainder of the heart.

Two recent studies of patients with paroxysmal AF have shown that catheter ablation is better than AAD therapy for maintaining sinus rhythm over two years.[12,13] These and other results have elevated catheter ablation to a first-line therapy for treatment of symptomatic patients with paroxysmal AF. Ablation of patients with persistent and even longstanding persistent AF has also been included as a reasonable approach in current guidelines for managing AF.[6]

In cardiac electrophysiology, catheter ablation is done either with heat or freezing, also known as Fire and Ice.[14] *Fire* refers to the use of radiofrequency current to heat up and modify the cardiac tissue of interest. *Ice* refers to the use of catheter balloons filled with nitrous oxide and cooled to below freezing. These tools are applied on the endocardial surface of the heart using catheters that allow for movement in and around every part of the heart. The comparative efficacy of fire or ice is still under investigation.

Will pulmonary vein isolation always be the standard for AF ablation? Will there be more specific ablation approaches allowing for shorter procedures with greater success? These are the questions being asked by EPs in 2015.

A concept called FIRM (focal impulse and rotor mapping) was introduced a few years ago with much fanfare in the EP community.[15] FIRM involves broad mapping of both atria with a large catheter to look for specific areas driving AF episodes outside of the pulmonary veins. Initial results were awe-inspiring. Not surprisingly, real-world use has proven less promising, but the concept got many wheels spinning. Now the Haissaguerre group is studying a way to place electrodes on the body surface to map the surface of the heart and look for areas driving AF episodes.[16] Another group of scientists is investigating ways to use cardiac imaging to find areas of atrial scar that may participate in driving arrhythmia.[17]

Finally, treating AF isn't all about the technology. In fact, recent research in clinical EP has shown that lifestyle modification is hugely important for AF patients. One recent study compared frequency of AF episodes among overweight patients who successfully lost weight vs. those who did not.[18] The results showed a startling six-fold reduction in episodes among those who lost more than 10% of their body weight. Another recent study paints a similar picture for AF patients who comply with a structured regimen of cardioendurance training.[19] There is also a close connection between AF severity and obstructive sleep apnea.[20] Awareness of sleep apnea and counseling about weight loss stand to help as many patients with AF as catheter ablation might.

In 2015, treatment for AF is much different than during my residency about a decade ago. EPs now have good ideas about how to treat this

disease and even dream of cures for some patients. The next few years hold great promise for treating patients with atrial fibrillation. ◇

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Join Us at the Latino Health Forum on Oct. 15

Enrique González-Mendez, MD

ALL LOCAL PHYSICIANS ARE INVITED to attend the 23rd annual Latino Health Forum on Thursday, Oct. 15, at the Flamingo Conference Resort and Spa in Santa Rosa. The theme of this year's conference is "A Call to Action for Latino Health," with a special focus on the recent *Portrait of Sonoma* report. This comprehensive study examines disparities in education, income and health outcomes in Sonoma County. The report highlights the social determinants of health and how the community can positively affect long-term health outcomes.

The all-day conference includes three keynote speeches and 10 workshops on Latino health. Speakers will share their expertise on the most important health, social and political conditions that affect the Latino community.

The morning's first keynote speaker is Oscar Chavez, the assistant director of human services for Sonoma County, who will discuss the *Portrait of Sonoma* report. He is followed by former Sonoma County Public Health Officer Dr. George Flores, who is now a program manager for the California Endowment. His topic is *The Portrait of California*, a state-wide version of the Sonoma report.

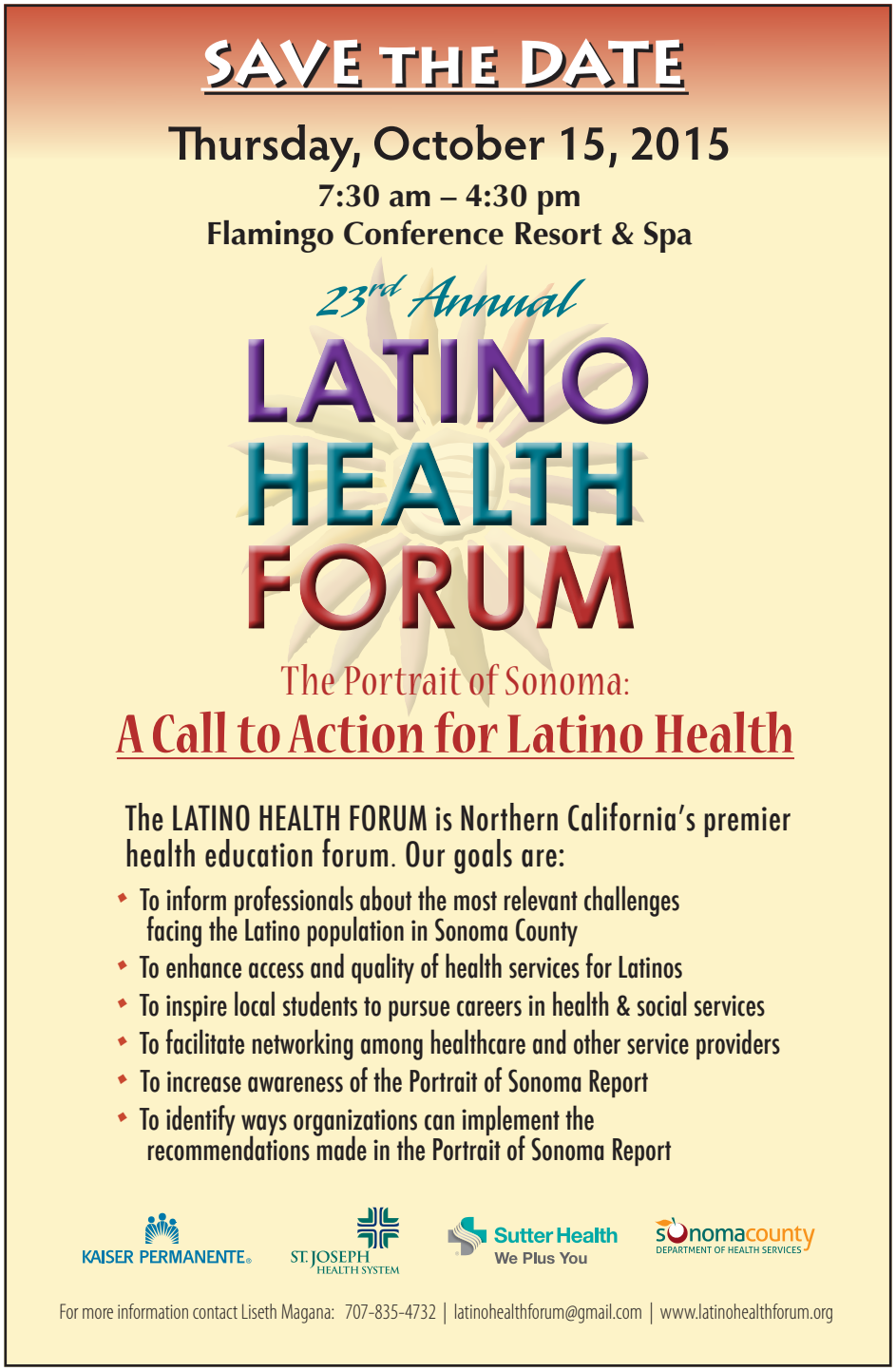
Also included in the morning's agenda is a brief update on Latino health in Sonoma County by the current Public Health Officer, Dr. Karen Milman. The afternoon speaker is Francisco Gonzalez, a professor of Latin American Studies at Johns Hopkins University. His topic is Latino participation and representation in American government.

The morning and afternoon workshops feature evidence-based models and population data that affect the way we care for Latino patients and provide social services. Topics include education, legal services, cardiovascular disease reduction, HIV care, community-centered health homes, immigration disparities, and nutrition and lifestyle changes.

To register for the conference, visit www.latinohealthforum.org.

One final note. This year marks the beginning of preparations for the Latino Health Forum's 25th anniversary celebration. Organizers are planning a great event, not only for Sonoma County, but also for the entire state of California. Readers are invited to share ideas for the celebration by contacting Liseth Magana at 707-835-4732 or latinohealthforum@gmail.com.

Dr. González-Mendez, a Santa Rosa family physician, chairs the Latino Health Forum Planning Committee.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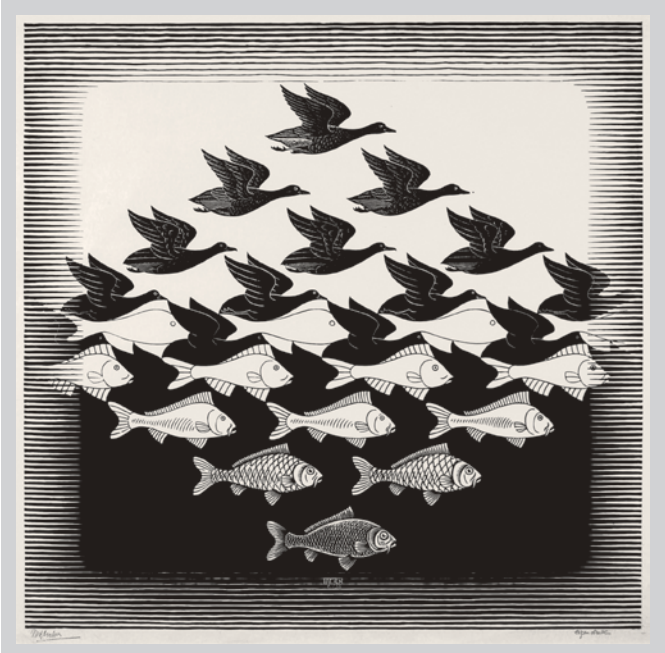
From Escherphilia to Escherology

Sal Iaquinta, MD



Sky and Water (1938)

Highly technical. A devotion to symmetry. Creative.

Those phrases sound like requirements for my job—I spend most of my days removing facial skin cancers and reconstructing the defects. But I'm actually talking here about the art of M.C. (Maurits Cornelis) Escher, the 20th-century Dutch printmaker whose idiosyncratic work enjoys wide popularity. Of course, anyone who knows me understands my attraction to Escher's art, but I hope I come off a bit less OCD than he does.

My adventure into the world of Escher started off like most. As a teenager, I was wowed by his impossible buildings and interlocked animals "infinitely filling" a plane. On my 18th birthday my mom took me to an Escher exhibit in Madison, Wisconsin. I left the show with a couple of Escher posters that traveled with me from dorm room to apartment throughout college. It sounds typical: Escher's work is often considered "college art" rather than "high art." Some might argue that it's gimmicky, but isn't that true of a lot of art? Splattering paint on canvas isn't a gimmick? How about painting soup cans?

Dr. Iaquinta is a San Rafael otolaryngologist.

Obviously I'm biased. I'll give the critics that Escher's output was prints, not paintings. Many people have no idea what an "original" print is. In Escher's day the question was a lot easier to answer—there were no computers, much less inkjet printers. Nowadays giclée printers reproduce images on canvas or paper with near-original quality.

For Escher, an original was printed from the "block." Escher's blocks were primarily woodcuts and lithographs. A woodcut is created by carving or etching an image into a flat wooden block and then rolling ink onto the block. The inked block is then pressed onto paper, like a giant stamp, creating an image.

Lithographs are a little more complex. An image is drawn on a flat stone surface with an oil-based pencil. Then, using water and oil-based ink, the image can be transferred to paper.

So, an original is whatever comes off the block—wood or stone—onto the paper. Escher had all of his blocks and stones deliberately destroyed upon his death, so the only original prints that exist were made in his lifetime. Moreover, Escher signed most of the larger prints. Some pieces were printed hundreds of times; others just a few.

Regardless of scarcity, I wanted one.

In the early 2000s I decided to try finding an Escher print. I discovered that a gallery in San Francisco had specialized in Escher's artwork for decades but had recently closed. So I did a Google search. A couple of options popped up. I called the first number, and it was the very man who had put on the show I saw in Madison. Now in Santa Cruz, he invited me to see some of his pieces and buy one. I made the trip and saw about a hundred works. A few things struck me that day. First, Escher had created a large body of work before the "gimmicks." Most of the images he created between ages 20 and 40 were Italian landscapes and cityscapes. Although they're not as famous, these early works highlight Escher's technical skill in much the same way that Dali's oeuvre from the period before he became a surrealist shows real talent for realism.

The second thing I realized is that art books don't do justice to Escher's

work. Shrinking a large, colorful woodcut down to a few inches and printing it in black and white on a page sandwiched between other works just doesn't work; but that's exactly the case in Escher's *catalogue raisonné*, the comprehensive listing of all his known work. Even the posters don't come close to his original work. Many of Escher's tessellated works (characterized by perfectly interlocked shapes, without overlaps or gaps) have a rigidity to them, especially when viewed in books. In actuality, they are printed on very delicate, handmade papers, which offset the stiff geometry of composition. The ink almost glistens as though still wet after all these decades. When you see it, you know it must not be touched.

I bought "Fishes and Frogs" (see page 1), a small transformative tessellation that embodies the very essence of Escher. At the top, fish swim in water. The spaces between the fish morph into frogs (which is what makes this tessellation a transformative one) as the fish themselves devolve into the land behind the frogs. This was a much smaller version of the far more famous "Sky and Water" in which birds and fish tessellate. But it was all I needed to find myself enthralled. I wanted to know more and see more. I was hooked.

Castrovalva *(1930) is one of Escher's most famous Italian works, yet you won't see it as a poster in dorm rooms. It shows an almost surreal, sweeping landscape, not far removed from the background of Belvedere. The scene is almost dizzying and full of fantasy, but not impossible like his future works. Escher takes a little liberty with perspective, by juxtaposing big and little: a normally "large" town appears tiny in the distance in the bottom right and a usually "small" beetle and snail appear huge in the lower left corner.*

Books offered a basic history of the man and his art, but I wanted more. The Escher Foundation's website wasn't very robust either. In fact, Escher's biography hasn't even been translated into English. One rumor is that the copyright holder thinks it portrays Escher poorly. Yes, Escher did go through a divorce, and he was probably a bit obsessive-compulsive. These days he might even be perceived as falling somewhere on the Asperger's spectrum. But the excerpts from his journals and letters that I've read portray an introvert with a gentle soul; a clever man who is constantly amazed by the wonders of nature and at the same time boyishly curious as to why her rules can't be broken. Escher tried to break them as subtly as he could. It's one thing to create impossible buildings; it's another to invent a creature that curls into a ball to roll around because "nature doesn't use the wheel."

So, in an effort to find owners and sellers and to collect and disseminate information, I created a website—eschersite.com—and filled it with nearly 600 images and a bucketful of "Escherology." A whole section is devoted to fakes and reprints—the things people think are real because along the way museums and others have made some convincing reproductions. It kills me to see people paying ridiculous sums for posters they think are originals. In the good old days, you could email other eBay bidders. When I told one bidder the "Hand with Reflecting Sphere" was a poster, he replied, "You're just trying to scare me off of bidding."

The site's popularity continues to grow. I've had the opportunity to meet with curators, former gallery owners, collectors who have met Escher, and even the owner of the Escher estate.

Belvedere ***(1958) is one of Escher's "impossible buildings." The entire building is based on the impossible cube the man at the lower left is holding. As with the cube, the top half of the building alone is entirely possible, and so is the bottom half. Only once pieced together does the building defy the rules of logic. Incidentally, the figures in the scene are borrowed from Hieronymus Bosch's triptych*** **Garden of Earthly Delights.** ***The background scenery is that of the Morrone Mountains in Abruzzo, Italy. Italian scenery continued to decorate the background of Escher's lithographs decades after he left Italy, where he lived for much of the 1920s and '30s.***

All images ©MC Escher Foundation. For more information, or to purchase original prints, visit www.eschersite.com.

I've contributed writings to museum catalogs. And the most fun: finding new homes for Escher artworks that former owners no longer want (or leave behind).

One highlight of these adventures was setting up a show in Rome at a mathematics festival. Yes, *festival* is the right word. The goal was to show students that there are exciting careers in mathematics, e.g., physicist, economist, computer scientist. I got to witness people's first impressions of Escher's art and watch their faces as they discovered the impossibility of works such as "Belvedere." (*Impossible* sounds so much better when exclaimed in Italian!) Thanks to a generous invitation, my girlfriend and I went out to dinner with some of the speakers—including five Nobel Prize winners. We shared a table with the now deceased John Nash—the inspiration for the movie *A Beautiful Mind*—and his family.

Escher belonged at that table of aging geniuses. Very few artists can make the claim that they continued to create better compositions with every passing year. Many artists, like many Nobel physicists, achieve acclaim for work they did in their 20s. Then they spend the remainder of their lives reliving, recreating and minutely tweaking the ideas that brought them recognition. But not Escher. He created "Belvedere" at age 60.

I hope I can say I'm doing my best work at age 60. I think I know how Escher did it. He never stopped exploring new ideas. He wasn't afraid to solicit others' advice. And he was patient enough to make sure everything he did was done as well as he possibly could. Sounds like a perfect recipe for success in medicine, too. ◇

Email: salvatore.iaquinta@kp.org

The Correct Diagnosis: Leprosy

Jeffrey Sugarman, MD

Both Dr. Debra Altemus, a Sebastopol dermatologist, and Dr. Ken Herrmann, an Indiana neonatologist, submitted the correct answer for the "mystery case" I described in the last issue: leprosy, also known as Hansen's disease. The other submissions ranged from mycosis fungoides and psoriasis to Grover's disease and atypical rheumatoid nodules.

In the case, a 42-year-old woman who grew up in Mexico presented at my office with mysterious red plaques on her face, trunk and extremities. She had already received several diagnoses followed by failed treatments. The initial diagnosis was poison-oak dermatitis, followed by fungal infection, hives, *H. pylori* infection and granulomatous dermatitis. On physical exam, I noted that her left ulnar nerve was enlarged enough to be palpable. This enlargement provided a clinical clue that the patient had leprosy.

Leprosy, caused by *Mycobacterium leprae*, is a chronic granulomatous infection that affects both the skin and the peripheral nerves. The disease targets peripheral nerves, causing inflammation and enlargement. A larger punch biopsy of an infiltrated plaque on the patient's forearm captured a cutaneous nerve root that showed the classic perineural granulomas characteristic of leprosy. Fite staining failed to reveal organisms, so I sent the sample to the national leprosy center in Baton Rouge, Louisiana, where further testing confirmed the diagnosis of leprosy.

Dr. Sugarman, a Santa Rosa dermatologist, chairs the SCMA Editorial Board.

The clinical manifestations of leprosy are variable and depend on host immunity to the *M. leprae*. Manifestations range from a few clinical lesions and good cellular immunity (tuberculoid leprosy) on one pole, to widespread lesions and poor immunity (lepromatous leprosy) on the other pole. Physicians need to have a high index of suspicion, as special stains for *M. leprae* are often negative in tuberculoid leprosy due to a paucity of organisms.

Leprosy is not endemic in the United States, except in the Southeast, where armadillos may be vectors for the disease. Accordingly, the vast majority of leprosy cases identified in the U.S. are in immigrants. In this case, the patient had almost certainly acquired leprosy before she immigrated from Mexico 27 years ago. The mechanism of *H. leprae* transmission is not known, but it is thought to occur via direct physical contact or by nasal secretions. Despite the fear and stigma surrounding leprosy, most people are not susceptible to acquiring the disease. An estimated 95% of Americans have natural immunity.

Type 1 lepra (reversal) reactions may occur during treatment. These acute inflammatory reactions lead to clinical worsening of the disease and possible further nerve damage.

In this case, the patient had received clarithromycin for her previous *H. pylori* infection diagnosis. The clarithromycin may have partially treated the *M. leprae* and led to a reversal reaction. After the diagnosis of leprosy was confirmed, the patient was started on rifampin and dapsone. She improved significantly within two months, and her treatment continued for a year. She remains free of leprosy. ◇

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A Healing Wildness

Rick Flinders, MD

H is for Hawk, Helen Macdonald, Grove Press, 288 pages (2015).

My father died 31 years ago and I still miss him. Every detail: his arm around my shoulders, his flannel shirt, the smell of tobacco on his hands. Most of all, I miss his smile and the blue of his eyes when he looked at me.

In *H is for Hawk,* the British writer Helen Macdonald describes the grief an adult daughter feels from the sudden loss of her father and, in her case, the paralyzing and prolonged aftermath that brings her personal and professional life to a halt. In this soaring memoir, she slowly and painstakingly returns to the world and to nature in the relationship she develops with a hawk and all that it represents.

She is the best new writer I can recall in the past 15 years. Her language is lyrical, powerful and succinct. In fact, you should be reading her right now and not me. Here's an example in which she recalls her first sight, as a 10-year-old girl, of a goshawk brought to a rescue center in the Gloucestershire countryside.

> We congregated in a dark ened room with the box on the table and the boss reached her gloved left hand inside. A short scuffle and then out into the gloom, her grey crest raised and her barred chest feathers puffed up into a meringue of aggression and fear, came a huge old female goshawk. Old because her feet were gnarled and dusty, her eyes a deep, fiery orange, and she was beautiful.
>
> Beautiful like a granite cliff or a thundercloud. She completely filled the room. She had a massive back of sun-bleached grey feathers, was as muscled as a pit bull, and intimidating as hell, even to staff who spent their days tending eagles. So wild and spooky and reptilian. Carefully, we fanned her great, broad wings as she snaked her neck round to stare at us, unblinking. We ran our fingers along the narrow bones of her wings and shoulders to check nothing was broken, along bones light as pipes, hollow, each with cantilevered internal struts of bone like the inside of an aeroplane wing. We checked her collarbone, her thick, scaled legs and toes and inch-long black talons. Her vision seemed fine too: we held a finger in front of each hot eye in turn. Snap, snap, her beak went. Then she turned her head to stare right at me.

Helen Macdonald's goshawk, Mabel.

It is easy to see why her prose has captured the critics and won multiple prizes. More important, it has captured readers, becoming the No. 1 bestseller in the United Kingdom. As one reviewer put it: "Writing so good it almost hurt to read . . . her words draw blood."

What draws such power from the author? Macdonald says, "This book is about two things: grief and hawks." As a child she became first enchanted and then obsessed by hawks. "I was not a popular girl. In fact, I had no other interests." More than anyone else in her life, she loved her father. Yet, except for the fact that he was killed suddenly in an automobile accident and was a professional nature photographer, we learn very little about him from the book. We learn far more about T.H. White, falconer and socially tortured author of *The Sword in the Stone* and *The Once and Future King*.

As a back story in the book, White mirrors Macdonald's fascination with goshawks and her sense of social isolation. As reviewer and author Richard Gilbert notes, "I wished for more on her father; this may be the fabled British reserve, as well as a writer's judgment about readers' interests, but without knowing more of their bond it was a bit harder to conjure the loss. How different . . . from we American memoirists who go crazy with grief."

"Crazy with grief," however, may well describe Macdonald's state of mind when she sets out to train perhaps the wildest species of the wildest bird in all of nature. Those who know them say you cannot find a wilder creature.

At first, I wondered if Macdonald's knowledge of birds was authentic, or

Dr. Flinders, who teaches hospital medicine at the Santa Rosa Family Medicine Residency, serves on the SCMA Editorial Board.

just hyperbole born from her "rapture with raptors." I was wrong to doubt. Her hawk knowledge is the real deal. Ornithologist Tim Gallagher observes: "Last fall, our own *Living Bird* magazine published a review that highlighted Macdonald's lyrical writing—but as a lifelong falconer I also give her high marks for providing a window into the minds of falconers and their birds. All of the accipiters can be difficult to train, but the goshawk is the worst, because it's so big and strong and fierce. There's even a falconry term, *yarak*, that refers to a state of bug-eyed, murderous intensity unique to goshawks when they are hungry. They have a reptilian edge. . . . If birds are truly dinosaurs, it's not difficult to imagine the goshawk's distant kinship with velociraptor!"

Forty years ago, ornithologist Jack Arnold, my professor at Sonoma State, told me: "The clue to understanding birds is to realize, evolutionarily, they are merely modified reptiles. Think of snakes who've modified their scales into feathers." Look closely into the eyes of Mabel, Macdonald's goshawk, in the photo on facing page. Looking at her is like looking into the eyes of a pit viper. This creature is able to achieve a speed, in full plummet, measured as high as 248 miles per hour. I don't even want to think about velociraptor.

So what do we learn from this book? We learn the author is a magnificent writer and a bird nerd. She misses her father so terribly that she trains and befriends one of the wildest creatures on earth in order to come to grips with the most painful condition in human experience: grief.

H is for Hawk is a fine and powerful read: raw, gorgeous, meditative—like the nature and creature Macdonald describes. If H is for hawk, I would suggest the W in *hawk* is for wild—and add that in wildness can be found not only the nature that can heal us but, as Thoreau reminds us, "the preservation of the world." ◇

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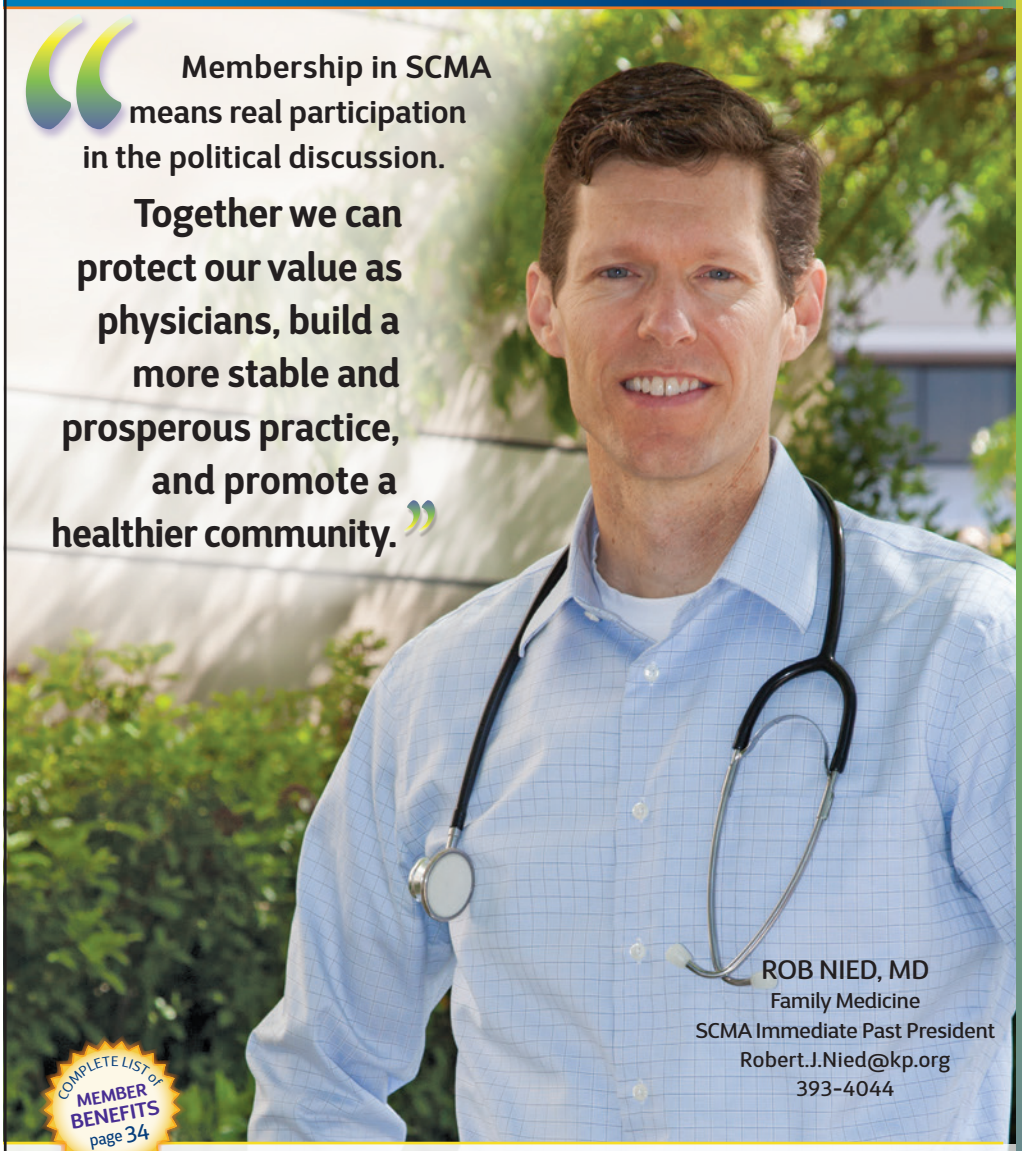
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Fifty Years of Expanding Opportunities

Maria Pappas

In 1965, the Sonoma County Medical Association and its Women's Auxiliary established what is now called the Health Careers Scholarship Fund. The fund helped students pursue degrees in medicine, nursing or other health-related fields. To secure donations for the fund, the Auxiliary (now called the SCMA Alliance Foundation) established the Holiday Greeting Card program. Local physicians and their families who donated to the scholarship fund were listed on the Holiday Greeting Card, which was then sent to all the donors. In the first year, beneficiaries of the fund included Santa Rosa Junior College nursing students who requested $25 to purchase a radio for their dorm room. How things have changed!

Today, the individual scholarship amounts awarded annually range from $1,000 for qualified high school students to $5,500 for students in medical school. Some students receive repeated annual awards as they make their way through undergraduate and professional school. Scholarship criteria include financial need, grade point average of 3.0 or higher, and family situation.

Close to 800 students have received scholarships over the past 50 years. Over the past 14 years alone, more than $250,000 has been awarded to these high-achieving young people.

Ms. Pappas is VP of marketing and communications for the SCMA Alliance Foundation.

While other benefit activities and fundraisers have been conducted to raise money for the scholarship fund, the Holiday Greeting Card has stood the test of time and continues to this day. One of the main features of the card is the original art on the cover. Local physicians, Alliance members, their families, and even children who have been served by Alliance programs create the art, making each year's card unique. The card allows scholarship donors to send holiday greetings to one another without having to mail their own separate cards.

We know that education is the single most effective strategy for ensuring that the workforce of tomorrow is skilled, entrepreneurial, innovative and prepared to succeed in 21st-century jobs. Yet, accessing higher education is more challenging now than it has ever been. Our Sonoma County students are poised to take on the hard work needed to learn and succeed in college and beyond, but they face many challenges, including less support by state governments, increasing tuition rates and decreasing financial aid. This is where awarding a Health Careers Scholarship to our best and brightest students can make a difference. For those students, the scholarship helps bridge the gap between family resources and the cost of higher education.

By making a commitment to our future doctors, nurses and other health care workers, you can help give 100% of the qualified applicants an award that will show them we believe in them and want to help fund their education. On the occasion of the Holiday Greeting Card's 50th Anniversary, the SCMA Alliance Foundation invites you to invest in tomorrow's leaders and help create a community whose young people are supported, educated and prepared to be productive and engaged citizens.

Because this is the 50th anniversary of the Health Careers Scholarship Fund, we hope to raise $50,000 during this year's Holiday Greeting Card campaign. By making a significant contribution to the Health Careers Scholarship Fund this year, you will help more students achieve their educational goals. Community members will ultimately benefit when these students enter the workforce as knowledgeable and caring health care professionals. Contributions can also help the SCMA Alliance Foundation endowment grow, guaranteeing awards for future scholarship recipients. (Members of SCMA and the SCMA Alliance Foundation administer this endowment with advisory assistance from 10,000 Degrees/ Sonoma County.)

Your donation can be made easily by visiting our website at **www.scmaa.org.** Click Donate and direct your gift to the Holiday Greeting Card. If you have any questions, contact Barbara Ramsey, Holiday Greeting Card Chairperson, at HolidayGreetingCard@scmaa.org. ◇

1965

1978

1988

2009

THE 2015 HOLIDAY GREETING CARD

Golden Anniversary

Celebrating 50 years of funding health career scholarships to local college students, and over 800 scholarships awarded since 1965!

The Holiday Greeting Card program creates scholarship funds through donations from members of the medical community like you. When you make a contribution, your name appears on a lovely card conveying seasonal greetings while building the health careers of tomorrow. Be a part of this joint effort of the SCMA and SCMA Alliance. Your donation will make a huge difference to local students pursuing their own medical professions.

Add your name to the card!

DONATE *in your name, or contribute "in honor of", or "in memory of" a loved one.*

CONTRIBUTE *as a way of acknowledging your own medical education commitment*

INVEST *in the future of medical care in our community*

HONOR *a tradition that is as essential and meaningful today as it was 50 years ago*

It's easy to become a Health Career Scholarship donor with one click on-line at **scmaa.org.** *All contributions for this year's greeting card must be received by* **December 4, 2015.** *For further information, please contact Barbara Ramsey, Holiday Greeting Card Chair, at 707-535-0747 or bj3ramsey@gmail.com.*

I wish to participate!

❍ $1,000 (Circle of Champions Level) ❍ $500 ❍ $250 ❍ $100 ❍ $75

Please indicate how you would like your name(s) to appear on the Holiday Greeting Card:

_____

I will be making my gift: ❍ in honor of ❍ in memory of _____

Make check payable to: **SCMAA Foundation** and mail to address below

Please charge my: MasterCard Visa (circle one)

Name on card _____ Account # _____

Billing Address _____ Exp Date _____

City, St, Zip _____ Phone _____

Mailing Address: ❍ Same as billing

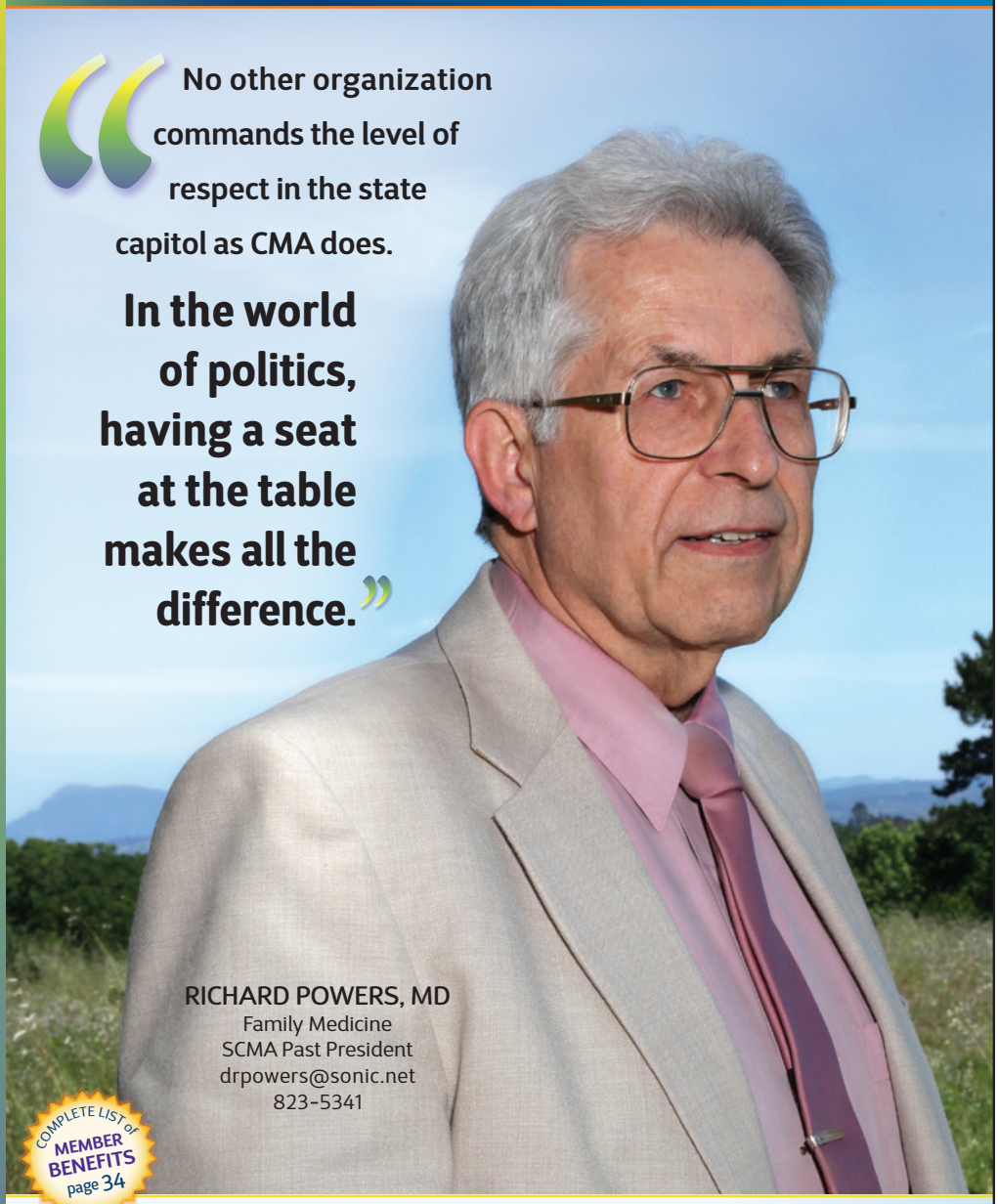
Street _____

City, St, Zip _____

Please return this form to Sonoma County Medical Association, 2312 Bethards Dr. #6, Santa Rosa, CA 95405. If your company has a Matching Gift Program, please enclose the form for us to complete.

Value of Membership

PRACTICE ◆ PROFESSIONAL ◆ PERSONAL


"No other organization commands the level of respect in the state capitol as CMA does.
In the world of politics, having a seat at the table makes all the difference."
RICHARD POWERS, MD
Family Medicine
SCMA Past President
drpowers@sonic.net
823-5341

COMPLETE LIST OF MEMBER BENEFITS page 34

Why SOLO/SMALL-GROUP PRACTICE PHYSICIANS *should be SCMA/CMA members:*

1. Speaking as a **united voice,** physicians exert a powerful influence on the political process. Organized medicine is the **"one voice"** that legislators and government hear.
2. **Free one-on-one** small practice resources including regulation compliance, contract analysis and billing, payment problems, and more with CMA's professional economic advocates and practice management experts at 800-786-4262.
3. SCMA/CMA worked diligently to **protect MICRA** (Medical Injury Compensation Reform Act), spearheading a successful campaign to defeat Prop. 46 in the 2014 election.
4. **Free medical-legal information** on contracts, subpoenas, employee relations, record retention, collections and more through CMA On-Call, a 24-hour online health law library.
5. Grow your **professional network and referral list** by networking with peers, established physicians, and health care leaders and legislators at SCMA/CMA events.

Join SCMA / CMA Now! • 707-525-4375 • scma@scma.org

NEW MEMBERS

Welcome, New and Returning SCMA-CMA Members!

NEW MEMBERS

Santa Rosa Family Medicine Residents

Jacqueline Abdalla, MD, Robert Wood Johnson Med Sch 2015

Kimberly Clinite, MD, Univ Chicago 2015

Anastasia Coutinho, MD, Univ Vermont 2015

Afsoon Foorohar, DO, Western Univ Health Sciences 2015

Dwiju Kumar, MD, Univ Iowa 2015

Kendall Madden, MD, Stanford Univ 2015

Guillermo Padilla, MD, UC Los Angeles 2015

Jessica Rhodes, MD, UC Davis 2015

Kayla Flores Tindall, MD, UC Davis 2015

Laura Vega, MD, Univ Southern Calif 2015

Stacie Vilendrer, MD, Stanford Univ 2015

Maya Zwerdling, MD, UC San Francisco 2015

TPMG - Santa Rosa

Win Thu Han, MD, Internal Medicine*, UC San Francisco 2007

Parisa Navi, MD, Pediatrics*, Tehran Univ 2001

Claudia Santucci, MD, Emergency Medicine*, UC Irvine 2003

Nathan Swain, MD, Physical Medicine & Rehabilitation*, Western Univ 2010

TPMG - Petaluma

Lindsey Hibbard, MD, Pediatrics*, UC Davis 2007

David Huang, MD, Psychiatry*, Univ Texas 2001

Danielle Mellace, DO, Internal Medicine, Western Univ 2009

Lisa Velasquez, MD, Family Medicine*, UC San Francisco 1999

Annadel Medical Group

Robert White, MD, Surgery*, Colon & Rectal Surgery, Cetec Univ 1982

RETURNING MEMBER

Northern California Medical Associates

Brian Schmidt, MD, Surgery*, Vascular Surgery, Univ Southern California 1982

* board certified

TOP 10 REASONS
To Join SCMA and CMA

Working together, the Sonoma County Medical Association and the California Medical Association are strong advocates for all physicians and for the profession of medicine. Of the many reasons for joining SCMA and CMA, 10 stand out:

1 COMMITMENT TO THE PROFESSION
By joining SCMA and CMA, physicians affirm their commitment to the profession of medicine and to preserving its honored place in modern society.

2 IMPROVING COMMUNITY HEALTH
SCMA is involved in several initiatives to improve community health in Sonoma County, such as increasing access for the uninsured and bolstering primary care.

3 LEGISLATIVE ADVOCACY
By speaking with a united voice, SCMA/CMA members exert a powerful influence on the political process at the local, state and national levels.

4 FOSTERING COLLEGIALITY
SCMA and CMA bring doctors from all parts of the medical community together—through leadership, cooperation and social gatherings.

5 FREE MEDICAL-LEGAL INFORMATION
CMA offers free medical-legal information on contracts, subpoenas, employee relations, collections and many other topics.

6 PRESERVING MEDICARE
Thanks to SCMA, CMA and other medical associations, recent attempts in Congress to cut the Medicare reimbursement rate have all been rebuffed.

7 PROTECTING MICRA
SCMA and CMA work diligently to protect the Medical Injury Compensation Reform Act (MICRA), which safeguards low liability insurance rates for California physicians.

8 PRACTICE MANAGEMENT
SCMA and CMA offer a wealth of resources to help physicians manage their practices, implement electronic medical records and qualify for federal incentive payments.

9 STAYING IN TOUCH
Through their magazines, newsletters and websites, SCMA and CMA encourage physicians to stay in touch with each other and with current medical news and events.

10 IT'S EASY AND FUN
To join SCMA and CMA, go to www.cmanet.org/join. Once you belong, it's fun to get involved in medical society projects and events.

ASK YOUR COLLEAGUES ABOUT SCMA AND CMA

One of the best ways to learn more about the benefits of membership in SCMA and CMA is to ask your colleagues. The physicians listed below have leadership roles at SCMA and would be happy to take your call.

President
Mary Maddux-González, MD
Family Medicine
707-285-2970
mmgonzalez@rchc.net

President-Elect
Regina Sullivan, MD
Obstetrics & Gynecology
707-393-4081
regina.t.sullivan@kp.org

Treasurer
Peter Sybert, MD
Anesthesiology
707-522-1800
pessramg@aol.com

Secretary
James Pyskaty, MD
Pediatrics
707-393-2052
james.x.pyskaty@kp.org

Board Representative
Brad Drexler, MD
Obstetrics & Gynecology
707-431-8843
b9drexler@gmail.com

Immediate Past President
Robert Nied, MD
Family Medicine
707-393-4044
robert.j.nied@kp.org

RIGHT NOW
is the best time to join SCMA and CMA.

- **Contact Rachel Pandolfi at SCMA**
  707-525-4375 or rachel@scma.org.

—OR—

- **Join online**
  at www.cmanet.org/join

S · C · M · A

CMA

MEMBERSHIP HAS ITS BENEFITS!

Free and discounted programs for SCMA/CMA members

BENEFIT	PARTNER
Auto/Homeowners Insurance *Save up to 10% on insurance services*	**Mercury Insurance Group** 888.637.2431 • www.mercuryinsurance.com/cma
Car Rental *Save up to 25% • Members-only coupon codes required*	**Avis or Hertz** 800.786.4262 • www.cmanet.org/groupdiscounts
Clinical Reference Guides *20% off subscriptions to Epocrates products*	**Epocrates discounted mobile/online products** www.cmanet.org/groupdiscounts
Financial Services *Up to $2,400 in savings on banking services*	**Union Bank** www.cmanet.org/benefits • www.unionbank.com/cma
Health Information Technology *FREE secure messaging application*	**DocbookMD** www.cmanet.org/groupdiscounts
HIPAA Compliance Toolkit *Various discounts; see website for details*	**PrivaPlan Associates, Inc.** 877.218.7707 • www.privaplan.com
ICD-10-CM Training *Deeply discounted rates on several ICD-10 solutions, including ICD-10 Code Set Boot Camps*	**AAPC** www.cmanet.org/aapc
Insurance *Life, Disability, Long Term Care, Medical/Dental, Workers' Comp, and more . . .*	**Mercer Health & Benefits Insurance Services LLC** 800.842.3761 cmacounty.insurance.service@mercer.com www.CountyCMAMemberInsurance.com
Legal Services *CMA On-Call, California Physician's Legal Handbook (CPLH) and more . . .*	**CMA's Center for Legal Affairs** www.cmanet.org/resources/legal-assistance 800.786.4262 • legalinfo@cmanet.org
Magazine Subscriptions *50% off all subscriptions*	**Subscription Services, Inc.** 800.289.6247 • www.buymags.com/cma
Medical IDs *24-hour emergency identification and family notification services*	**MedicAlert** 800.253.7880 • www.cmanet.org/groupdiscounts
Medical Waste Management *Save 30% or more on medical waste management and regulatory compliance services*	**EnviroMerica** www.cmanet.org/groupdiscounts 650.655.2045 • www.enviromerica.com
Mobile Physician Websites *Save up to $1,000 on unique website packages*	**MAYACO Marketing & Internet** 209.957.862 • www.mayaco.com/physicians
Office supplies, facility, technology, furniture, custom printing and more . . . *Save up to 80%*	**StaplesAdvantage** 800.786.4262 • www.cmanet.org/groupdiscounts
Physician Laboratory Accreditation *15% off lab accreditation programs and services* Members-only coupon code required	**Commission on Office Laboratory Accreditation (COLA)** 800.786.4262 • www.cmanet.org/groupdiscounts
Reimbursement Helpline *FREE assistance with contracting or reimbursement*	**CMA's Center for Economic Services (CES)** www.cmanet.org/resources/reimbursement-assis 800.401.5911 • economicservices@cmanet.org
Security Prescription Products *15% off tamper-resistant security subscription pads*	**RxSecurity** www.cmanet.org/groupdiscounts To order: 800.667.9723 • www.rxsecurity.com/cma-order

PUBLICATIONS

CMA Publications

www.cmanet.org/news-and-events/publications/

- ***CMA Alert*** **e-newsletter**
- ***CMA Practice Resources***

CMA Resource Library & Store

www.cmanet.org/resource-library/list?category=publications

- **Advance Health Care Directive Kit**
- **California Physician's Legal Handbook**
- **Closing a Medical Practice**
- **Do Not Resuscitate Form**
- **HIPAA Compliance Online Toolkit**
- **Managed Care Contracting Toolkit**
- **Model Medical Staff Bylaws**
- **Patient-Physician Arbitration Agreements**
- **Physicians Orders for Life Sustaining Treatment Kit**

SCMA Publications

www.scma.org

- ***Sonoma Medicine*** (quarterly)
- ***Sonoma County Physician Directory*** (annual)
- ***SCMA News Briefs*** (monthly)

CONTACT SCMA/CMA: 707-525-4375 • scma@scma.org

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O 541.864.5053
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dblanchard@harryanddavid.com

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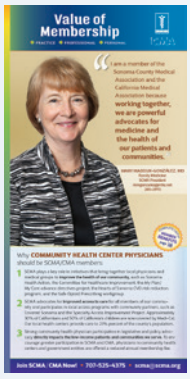
The Value of SCMA/CMA Membership

Cynthia Melody, MNA

Last year was monumental for both the California Medical Association and the Sonoma County Medical Association. SCMA/CMA physicians from all modes of practice and specialties came together to defeat Proposition 46, which would have dramatically increased malpractice insurance rates. Physicians also triumphed in the 15-year battle to fix inequities in Medicare's geographic practice cost index (GPCI) for Sonoma County, and in eliminating Medicare's sustainable growth rate (SGR) formula.

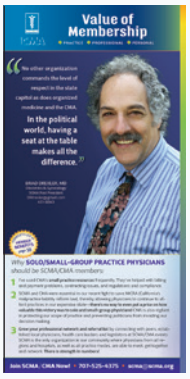
It is vital that SCMA and CMA continue the momentum that depends so heavily on membership. Now is the time to join SCMA/CMA or to renew your membership for 2016. If you're already a member, ask your non-member colleagues to join.

We've been running SCMA/CMA Value of Membership ads in *Sonoma Medicine*. In the ads, several local medical leaders identify reasons why physicians practicing in Sonoma County should be SCMA/CMA members. Here's what they say:



"Working together, we are powerful advocates for medicine and the health of our patients and communities."

—Mary Maddux-González, MD


Value of Membership
In the political world, having a seat at the table makes all the difference."
Why SOLO/SMALL-GROUP PRACTICE PHYSICIANS should be SCMA/CMA members

"In the political world, having a seat at the table makes all the difference."

—Brad Drexler, MD

"Together we can protect our value as physicians, build a more stable and prosperous practice, and promote a healthier community."

—Regina Sullivan, MD

Benefits and Initiatives

You can benefit from SCMA/CMA membership whether you are a specialist or a primary care physician . . . whether you practice solo or in a group . . . whether you work in a community health center, a medical office building or a hospital. Your membership also supports several community health initiatives.

Here are just a few SCMA/CMA benefits and initiatives:

Community Health. SCMA is involved in Sonoma Health Action, the Committee for Healthcare Improvement, the Hearts of Sonoma CVD risk reduction program, and the My Care My Plan project for advance care planning. SCMA also supports projects to increase access for the uninsured … to improve oral health … to encourage vaccinations … to promote safe prescribing of opiates … to regulate tobacco use … and on and on.

Legislative Advocacy. When physicians speak with a united voice, they exert a powerful influence on the political process. CMA and its component medical societies are the one medical voice that legislators and government hear. Last year, for example, CMA advocacy held off a 10% Medi-Cal cut and kept optometrists from practicing ophthalmology.

Economic Services. CMA has recouped $10 million from payors on behalf of physician members over the past five years. SCMA/CMA members get free one-on-one assistance to identify, prevent and fight unfair payment practices. Just call the Reimbursement Helpline at 888-401-5911. For other issues, call the CMA Member Help Center at 800-786-4262.

Join Now!

Fifty-four percent of practicing Sonoma County physicians are already SCMA/CMA members. If you're not a member, join now by visiting **www.cmanet.org/join** or by contacting SCMA at 707-525-4375 or scma@scma.org.

Ms. Melody is executive director of the Sonoma County Medical Association.

Email: cmelody@scma.org

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